



## Cwm Taf Morgannwg Weight Management Pathway Proposal

July 2021

### Contents

|  |    |
|--|----|
| PURPOSE .....  | 2  |
| STRATEGIC CONTEXT .....  | 2  |
| WEIGHT MANAGEMENT DURING PREGNANCY.....  | 3  |
| DEVELOPING A CHILDREN AND YOUNG PEOPLE'S PATHWAY.....                            | 3  |
| COMMISSIONING OF HENRY .....   | 4  |
| UNDERSTANDING NEED.....  | 5  |
| REQUIREMENT FOR AN ADULT WEIGHT MANAGEMENT SERVICE AWMS .....                    | 7  |
| PROPOSED SERVICE PATHWAY .....   | 7  |
| LEVEL 1: INFORMATION AND SIGNPOSTING .....                                       | 9  |
| COORDINATION OF THE SERVICE .....  | 10 |
| LEVEL 2 WEIGHT MANAGEMENT OPTIONS .....  | 10 |
| LEVEL 3 MDT SERVICE .....  | 13 |
| LEVEL 4 BARIATRIC SERVICE.....   | 13 |
| RESEARCH AND DEVELOPMENT .....   | 15 |
| INTEGRATED L2/3 ADULT WEIGHT MANAGEMENT SERVICE CAPACITY, COSTS AND ROLES.....   | 15 |
| IMPLEMENTING THE SERVICE.....  | 19 |
| COORDINATING PROGRAMMES OF WORK ACROSS CTMUHB RELATED TO WEIGHT MANAGEMENT ..... | 20 |
| COST AVOIDANCE .....   | 21 |
| CONCLUSIONS.....   | 21 |
| RECOMMENDATIONS .....  | 21 |
| Appendix 1: Weight Management Pathway for Pregnant Women BMI > 30 .....          | 22 |
| APPENDIX 2: LEVEL 3 MDT ROLES.....   | 22 |
| REFERENCES:.....   | 25 |

## PURPOSE

This document outlines the obesity pathway that currently operates in Cwm Taf Morgannwg University Health Board as well as a draft proposal for an integrated level 2/3 adult weight management service for the health board.

This pilot will be funded by the settlement from Healthy Weight Healthy Wales. Proposal A focuses on a costed scenario that makes use of the available funds from Health Weight Healthy Wales to create a Level 3 service and will increase capacity in an existing Level 2 programme called Joint Care.

Proposal B includes a comprehensive proposal that will enable the health board to treat a wider number of patients and further meet population needs. Funding for this proposal has not yet been identified.

## STRATEGIC CONTEXT

### Background

Previous proposals for the development of Level 2 and 3 weight management services for adults in Cwm Taf were taken to Executive Board in 2015, 2018 and 2019. The plans were agreed in principle. However, they were not progressed.

Welsh Government has produced a 10 year strategy to address obesity in Wales.

The Final Draft of the All Wales Adult Weight Management (AWM) Pathway was published in March 2021.

The health board response to Covid-19 and staff redeployment paused development of the pathway until recommencement of this work began in spring 2021.

The proposals in this document reflect the stipulations and standards in the All Wales Pathway. Cwm Taf Morgannwg's 'Live Well' service will be established on the principles of delivery without stigma whilst ensuring each level of the pathway is psychologically informed.

Adults with a body mass index above 30 are at increased risk of many illnesses and hospitalisation for associated illnesses, including Covid-19.

## **WEIGHT MANAGEMENT DURING PREGNANCY**

Cwm Taf Morgannwg (CTM) has a well-defined weight management during pregnancy programme called BUMP start. We know that around 34% of pregnant women in CTM who book in to appointments are obese. The Public Health Midwife, alongside all community midwives, utilise the "Foodwise in pregnancy" package to support women with a BMI of 35-39.9.

The Public Health Midwife sees women with a BMI over 40 at 16, 24 and 36 weeks. In 2020-21, average weight gain in this group was 5.2kg. An additional 0.6 full time equivalent Midwife post has been recruited to ensure delivery is extended to include the Bridgend locality.

Please see Appendix 1 for the Weight Management Pathway for obese women. Evaluation and further details are available on request and the lead Public Health Midwife has given information and an update to the All Wales Weight Management Services During Pregnancy meeting.

## **DEVELOPING A CHILDREN AND YOUNG PEOPLE'S PATHWAY**

Initial work has been to progress the overdue development of an integrated adult weight management pathway in Cwm Taf Morgannwg.

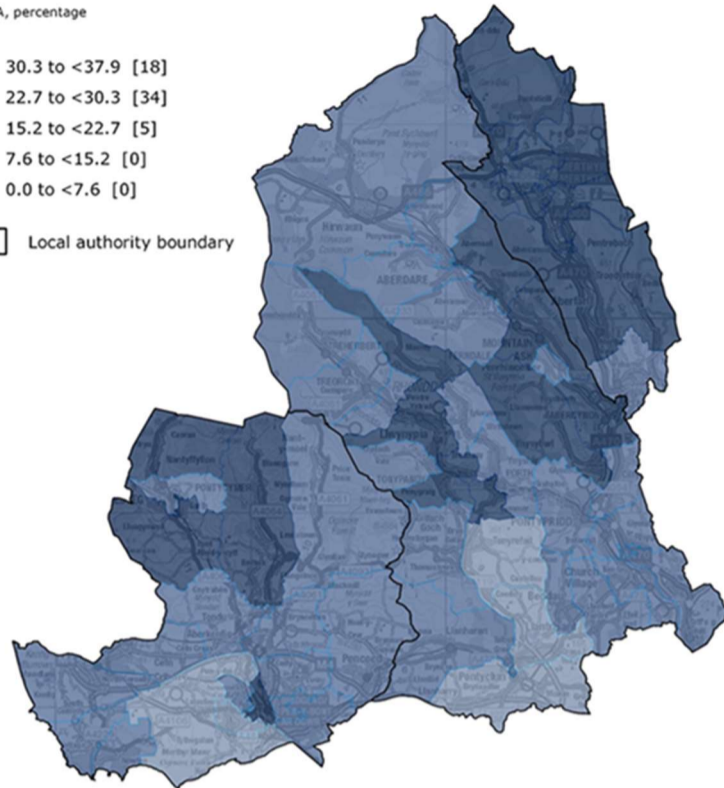
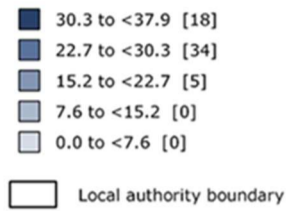
A multidisciplinary working group has been convened to meet in July 2021 to progress the recommendations of the All Wales Weight Management Pathway (Children, Young People and Families): Core Components document.

Childhood obesity is associated with psychological problems and obese children are at greater risk of developing a number of serious diseases such diabetes, cancers and type 2 diabetes<sup>1</sup>.

From the Childhood Measurement Programme data we know that overweight, obesity, and severe obesity in children (aged 4/5) in Cwm Taf Morgannwg University Health Board area are all significantly above the Wales average. The map shows the percentage of children who are overweight or obese, in some areas this is more than a third of 4 and 5 year olds.

**Percentage of children aged 4 to 5 years who are overweight or obese, Cwm Taf Morgannwg UHB, Child Measurement Programme for Wales, 2012/13 - 2016/17**

MSOA, percentage



### **What is the population health impact?**

The impact of preventing obesity on the health of the population, particularly from a young age is substantial. Interventions in the early years have the potential to have a lifelong impact and to reduce the impact of inequalities. This particular intervention meets several of the priorities of the prevention and early year's fund.

### **COMMISSIONING OF HENRY**

Cwm Taf Morgannwg has commissioned the HENRY Programme. HENRY – Healthy Exercise and Nutrition for the Really Young – trains practitioners to work more sensitively and effectively with babies, preschool children and their parents around obesity and lifestyle concerns. It places a particular emphasis on parenting/carer skills and is one of very few initiatives that focus on the first two years of life.

The HENRY programme fully complies with [NICE guidance PH47](#) on the core components of weight management and lifestyle programmes.

HENRY is being coordinated by a practitioner within the Local Public Health Team. Covid-19 restrictions has resulted in HENRY being delivered via digital means. Work is progressing to move to a hybrid model when delivery begins in Q3 of 2021/22. Recruitment of the HENRY workers has recently been completed and training of HENRY delivery staff will begin in June 2021.

Recruitment of families will begin in the summer of 2021 with delivery of the programme scheduled for commencement in September 2021. Planning is taking place to ensure that the HENRY programme links closely to the proposed Weight Management Service to ensure cross referral and signposting can take place. This will follow a whole-family approach, given that obesity is often intergenerational.

## UNDERSTANDING NEED

According to the population projection from 2019, the population of Cwm Taf Morgannwg currently stands at 448,639.

Cwm Taf Morgannwg has some of the highest rates of obesity in Wales. The latest available data for BMI 35 + from the National Survey for Wales is shown below.

| Adults with a BMI of 30+, 35+,40+ and 50+, estimated count, persons aged 16 and over, Cwm Taf Morgannwg UHB and Wales, 2016/17-2017/18  |  |                             |  |                             |  |                           |  |                          |
|---|--|-----------------------------|--|-----------------------------|--|---------------------------|--|--------------------------|
|   | BMI 30+                                      |                             | BMI 35+                                      |                             | BMI 40+                                      |                           | BMI 50+                                      |                          |
|   | Estimated count<br>(95% confidence interval) |                             | Estimated count<br>(95% confidence interval) |                             | Estimated count<br>(95% confidence interval) |                           | Estimated count<br>(95% confidence interval) |                          |
| Cwm Taf Morgannwg UHB   | 104,500                                      | (95,400 to 113,600)         | 38,400                                       | (31,900 to 44,800)          | 10,600                                       | (7,500 to 13,700)         | 2,000  | (600 to 3,400)           |
| <b>Wales</b>  | <b>610,700</b>                               | <b>(588,800 to 632,700)</b> | <b>194,500</b>                               | <b>(180,900 to 208,100)</b> | <b>59,300</b>                                | <b>(52,100 to 66,500)</b> | <b>10,700</b>                                | <b>(7,600 to 13,800)</b> |
| Produced by Public Health Wales Observatory using NSW (WG) and mid-year estimates (ONS)<br>Estimated counts have been rounded to the nearest 100<br>Around 10% of records contain missing data. Care should be taken when interpreting these results. |  |                             |  |                             |  |                           |  |                          |
| Adults with a BMI of 30+, 35+,40+ and 50+, observed percentage, persons aged 16 and over, Cwm Taf Morgannwg UHB and Wales, 2016/17-2017/18  |  |                             |  |                             |  |                           |  |                          |
| Health Board  | BMI 30+                                      |                             | BMI 35+                                      |                             | BMI 40+                                      |                           | BMI 50+                                      |                          |
|   | Percentage<br>(95% confidence interval)      |                             | Percentage<br>(95% confidence interval)      |                             | Percentage<br>(95% confidence interval)      |                           | Percentage<br>(95% confidence interval)      |                          |
| Cwm Taf Morgannwg UHB   | 28.9   | (26.4 to 31.4)              | 10.6   | (8.8 to 12.4)               | 2.9  | (2.1 to 3.8)              | 0.6  | (0.2 to 0.9)             |
| <b>Wales</b>  | <b>23.8</b>                                  | <b>(22.9 to 24.7)</b>       | <b>7.6</b>                                   | <b>(7.1 to 8.1)</b>         | <b>2.3</b>                                   | <b>(2.0 to 2.6)</b>       | <b>0.4</b>                                   | <b>(0.3 to 0.5)</b>      |
| Produced by Public Health Wales Observatory using NSW (WG)<br>Around 10% of records contain missing data. Care should be taken when interpreting these results.   |  |                             |  |                             |  |                           |  |                          |

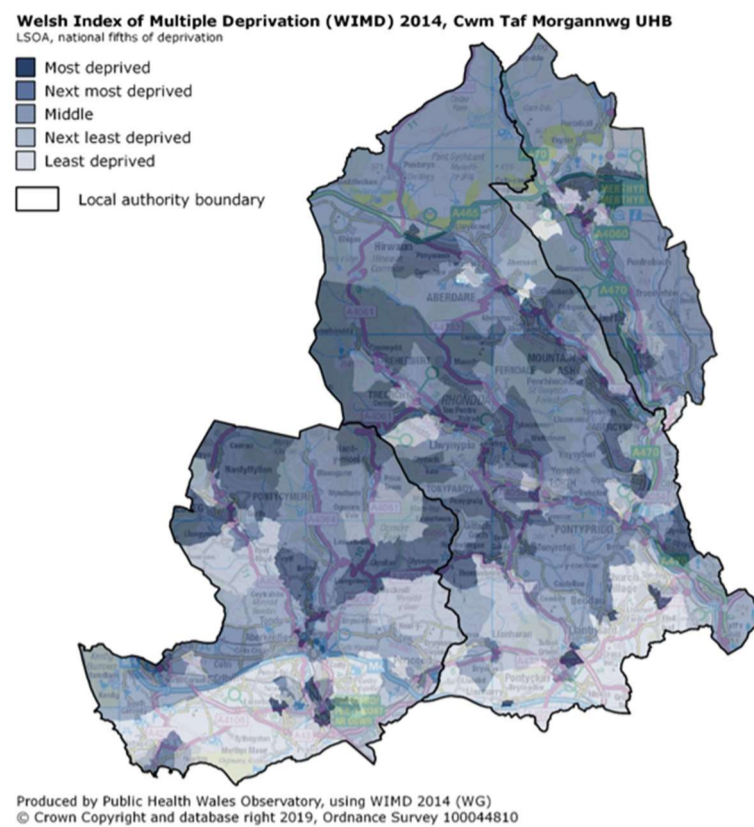
Combined data from 2018-19 and 2019-20 shows that 27% of adults in Cwm Taf Morgannwg are obese; this is the second highest among health boards in Wales and amounts to 121,000 people.

*Care should be taken when interpreting these results and they are included in this pathway proposal for indicative purposes.*

## Deprivation and obesity

Obesity is closely associated with deprivation. Bridgend has similar levels and distribution of deprivation to Rhondda Cynon Taf and Merthyr Tydfil.

We propose to deliver our psychologically informed Healthy Weight MECC training to Primary Care Clusters with the highest density of deprivation in the first instance then cascading the training to the remaining clusters across Cwm Taf Morgannwg.



### Growing Demand

The health consequences of obesity are well documented and the resultant economic costs to health services are escalating.

Public Health Wales has regularly conducted engagement surveys throughout the pandemic. The most [recent](#) findings have demonstrate that during the pandemic a significant proportion of the public say their weight has increased:



## REQUIREMENT FOR AN ADULT WEIGHT MANAGEMENT SERVICE AWMS

NICE guidance PH53 (2014)<sup>2</sup> recommends the adoption of an integrated approach to managing obesity with systems in place to allow people to be referred to different levels of the obesity pathway, as necessary.

More recently, Welsh Government's Healthy Weight: Healthy Wales strategy stipulates the development of a clinical pathway to ensure those who are overweight or obese can access the right kind of support.

Due to the redeployment of health board and local public health team staff in response to Covid-19, CTM's Adult Weight Management Pathway Development Group was paused.

In March 2021, the group was reconvened to expedite the pathway. Three meetings have taken place and a Task and Finish sub group has taken forward and developed the following proposals in this document.

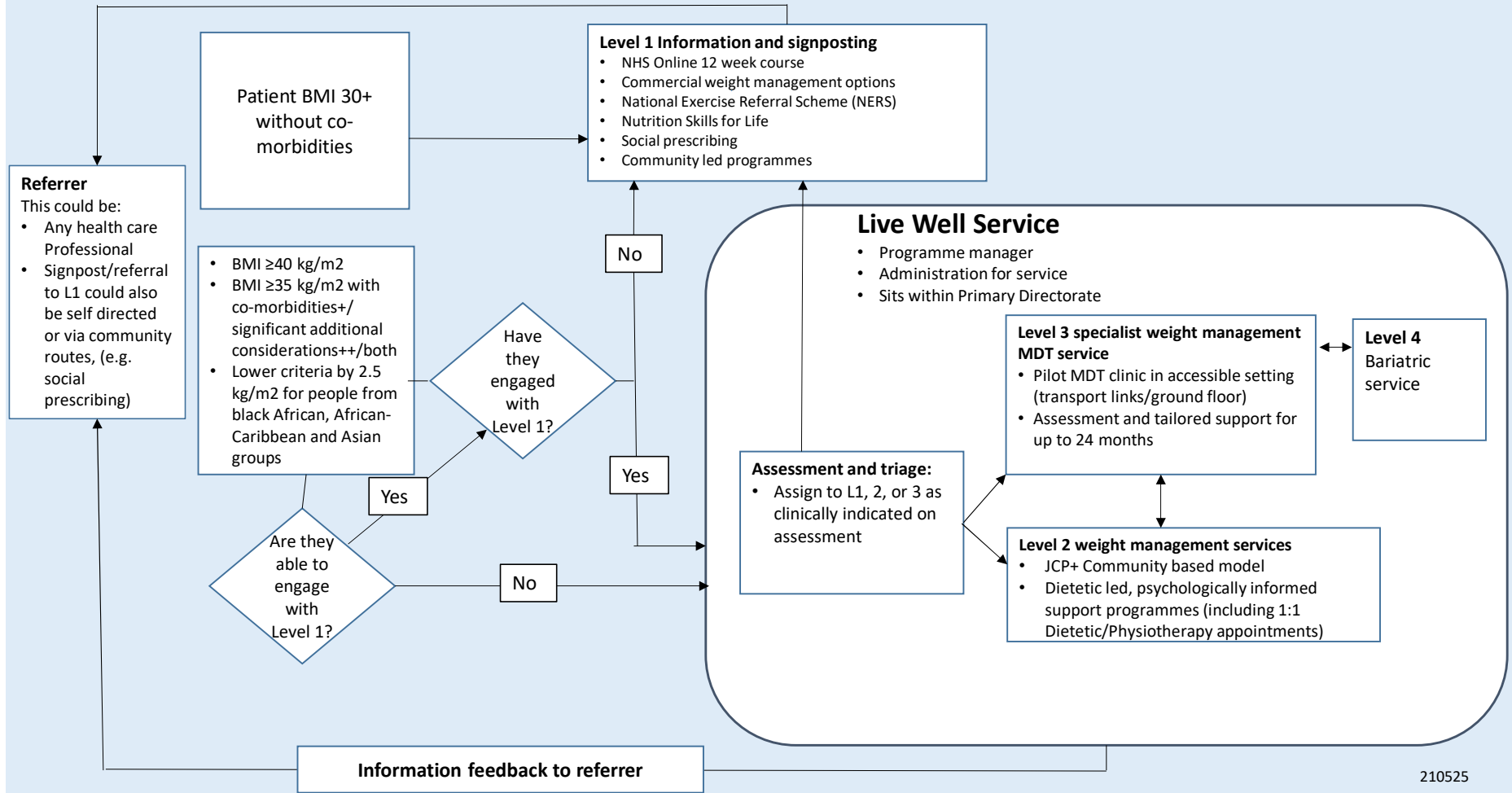
## PROPOSED SERVICE PATHWAY

This model involves the development of a single point of access to support the integrated service. Referrals will be processed by the proposed service and patients triaged into the appropriate level.

We anticipate developing the level 3 model as a pilot in one area of Cwm Taf Morgannwg with service user, staff feedback and evaluation informing the development of the service across the geographic area that the health board service.

The proposed weight management service pathway is outlined on the following page.

# CTM Proposed Weight management services pathway



210525

## LEVEL 1: INFORMATION AND SIGNPOSTING

Following the principles of prudent health care – ‘doing only what is needed’, patients with BMI 30+ without co-morbidities should be signposted to Level 1 community services/ self-care options in the first instance.

Any health care professional can do this using the Making Every Contact Count (MECC) approach.

The health board has embraced MECC, which aims to:

1. Empower staff to have healthy conversations by developing appropriate knowledge, skills and confidence
2. Embed the MECC approach through considering and adapting departmental systems and processes that enable staff to have healthy conversations
3. Encourage staff to consider their own health and wellbeing and through conversations, influence that of their families, friends and colleagues

Making Every Contact Count (MECC) has the potential to normalise the discussion of health behaviours and wellbeing in a non-judgemental way and help to ensure that a preventative culture is adopted across organisations. Not every contact with a patient will have a successful outcome, but by consistently highlighting messages and suggesting possible change, more patients will be supported to make positive changes to their lifestyle.

Dedicated MECC ‘healthy weight conversation’ training will be developed with input from the proposed ‘Live Well’ MDT and offered to primary care clusters with the highest levels of deprivation, targeting those most at need as set out in the standards pathway document. This training will be developed with support from the Clinical Psychologist and will be psychologically informed.

This training will enable conversations (based on Motivational Interviewing principles) that support lifestyle change and facilitate patient access to support/services, to become routine.

## COORDINATION OF THE SERVICE

The AWMS team comprises:

- A programme manager responsible for:
  - The organisation of the service
  - Staff training
  - Service planning, monitoring, research and evaluation
- Administration support:
  - Handling referrals, scheduling appointments, waiting list management, data collection
- All referrals into the integrated Level 2/3 obesity service would be triaged. Initially this would be a paper triage undertaken by administration staff following set criteria and clear indicators of whether the patient could be referred back to Level 1. This would be followed by a clinical triage including highly specialist assessment of psychosocial and functional patient needs, and may be by telephone, face to face or via digital means. This will ensure patients are signposted to the correct pathway (Level 2 or 3) and the correct treatment option within these pathways. It is envisaged that the healthcare professional in this post could be a dietitian, physiotherapy, psychologist or senior nurse but would be integrated into the clinical teams at Level 3 to ensure continuity of care and likelihood to recruit and retain into this position.

The Live Well team will be located together in one base. This requires office accommodation and the necessary equipment to function. Potential bases have been identified and will be explored further once the peer review process has taken place.

## LEVEL 2 WEIGHT MANAGEMENT OPTIONS

Sufficient capacity at Level 2 of the pathway will minimise the risk of inappropriate referrals directly to the Level 3 service, whilst providing the appropriate management of patients up/down from Level 3. Recognising the need to retain patients in Level 2 weight management services long enough to achieve effective weight loss, patients would be offered the choice of treatment in group or one-to-one weight management programmes. Any preference would be established at the triage and assessment stage.

NICE guidance and the All Wales Pathway recommends:

- Programmes last at least 12 weeks. However, obesity is a chronic condition that may require longer treatment and people should be given the opportunity for a re-referral.

- Patients will be offered a group or a 1:1 appointment before they join the Level 2 service. Additional dietetic support has been costed in to the JCP+ proposal to utilise MI skills and motivate patients to attend a group programme. Groups programmes have been shown to be effective, utilising a peer approach and support.
- Programmes should focus on long term lifestyle change and prevention of future weight gain
- Programmes should ensure they deliver an average weight loss of at least 3%, with at least 30% of participants losing at least 5% of their initial weight.
- Programmes should be monitored and evaluated.
- Programmes must complete the feedback loop to the referrer to ensure health care practitioners continue to refer patients in to the service.

## Level 2 options

A systematic review<sup>3</sup> examined the critical features of successful Level 2 weight management programmes (WMPs) and concluded that the most successful programmes were characterised by:

- Supportive relationships with both providers and peers. This engendered social bonds, which fostered attendance at WMP sessions, initiation of healthy behaviours and self-regulation or maintenance of healthy behaviours
- A high level of support and direction from providers
- **Flexible service provision in order to meet the needs and preferences of service users.**

The expansion of the Joint Care Programme will include dedicated referrals of patients living with obesity.

An additional Level 2 service, led by dietetics, is proposed and is costed below. We believe that implementing the whole service will better fit the needs of the Cwm Taf Morgannwg population though **funding for the whole model has not yet been identified.**

Primary Care Clusters will be recommended to support the Live Well pathway by continuing to invest in vouchers for private weight management providers (meeting NICE guidance) to offer plurality of choice for patients.

## JCP+ – community delivered model based on Joint Care Programme

Since 2013, the health board has commissioned Rhondda Cynon Taf Local Authority (RCT) and Merthyr Tydfil Leisure Trust (MLT) to deliver the Joint Care Programme (JCP). JCP is a 12-week exercise and nutrition intervention targeted at overweight and obese patients (BMI 28+) with chronic knee and/or hip pain. The programme is traditionally delivered in community leisure venues but since the outbreak of the Covid-19 global pandemic JCP delivery has been paused. In May 2021 delivery of a

digital JCP was re-established across the whole Cwm Taf Morgannwg patch including the Bridgend locality. The LPHT and Dietetic team will be closely evaluating the outcomes of the digital model to understand the uptake and impact of this type of delivery.

JCP has consistently demonstrated positive mean improvements across all measures and has improved pain and function in participants. The latest available returns showed average of 2.62kg weight loss and decreased waist measurement of 4.13cm over the 12-week intervention. For the financial year 2018/19 around 420 patients engaged with the programme with 50% of those fully completing with positive outcomes. Feedback from participants has stated that they find community centred leisure locations convenient and more likely to attend the full programme of 12 weekly sessions. JCP has been evaluated over a 6 year period showing consistent results and effectiveness. This programme has an existing and positive relationship with health board referrers and members of the public.

The same model, expanded to include specifically referred obese patients and rebranded as the JCP+ programme will focus on weight management and would complement the existing JCP whilst forming part of the Cwm Taf Morgannwg Weight Management Pathway.

As far as possible, Level 2 services should be based in community venues and this may incur costs. Given that obesity is a priority for the Public Services Board (PSB), a further proposal may be submitted to the PSB seeking the agreement of partners to provide venues free of charge, particularly if their staff would benefit from a Level 2 service.

In addition to the weight management programmes offered at Level 2, the Specialist Clinical Psychologist will ensure, via training and the integrated model, that delivery at Level 2 and Level 3 is psychologically informed.

There is evidence to suggest that employees who are overweight and obese take more days of sickness absence in comparison to 'normal weight' employees. Research has also suggested that increased sickness absence results from obesity related health conditions<sup>4</sup>. In addition, NICE guidance CG43 recommends that:

- *All workplaces, particularly large organisations such as the NHS should address the prevention and management of obesity, because of the considerable impact on the health of the workforce and associated costs.*

*It is a recommendation that a future proportion of Level 2 weight management programmes should be offered to health board staff and wider PSB organisation staff once delivery has commenced and capacity can be increased.*

## Data collection for Level 2 services

Key performance indicators for Level 2 adult weight management services are stipulated in the All Wales Adult Weight Management Pathway and will be adhered to.

### LEVEL 3 MDT SERVICE

The aim of this service is to improve the health and wellbeing of adults with severe and complex obesity, and complex physiological and psychological health needs, by supporting them to achieve and maintain a healthier weight through making appropriate and sustainable lifestyle changes to their eating habits and Levels of physical activity. The health board will achieve this through the establishment of a multidisciplinary team (MDT) to function at Level 3 of the All Wales Adult Weight Management Pathway.

The specification identifies the minimum requirements for the Level 3 MDT services to fulfil their function as the route for patients into, and out of, Level 4 bariatric surgery in line with Welsh Health Specialised Services Committee (WHSSC) criteria.

The Level 3 MDT will comprise specialists including:

- Physician
- Dietitian
- Psychologist
- Physiotherapist
- Other Appropriate Professionals

Descriptions of the specialist roles in the Level 3 service are given in **Appendix 1**.

### LEVEL 4 BARIATRIC SERVICE

Bariatric surgery (Level 4) is widely recognised as the most effective treatment for people with morbid obesity to allow substantial, sustained weight loss and to improve or resolve obesity-associated comorbidities such as diabetes, thereby reducing mortality<sup>5</sup>.

Level 4 services are jointly commissioned on behalf of all Health Boards by Welsh Health Specialised Services Committee (WHSSC). Currently, the lack of Level 2/3 services in Cwm Taf Morgannwg means that access to Level 4 services for our patients is suboptimal. Some CTM UHB patients have had treatment at Level 4. The provision of after-care and weight management support for the patient remains a lifetime commitment. Structured, systematic and team based follow-up is organised

by the bariatric surgery provider for 2 years. After 2 years, patients are transferred back to their GP and local Tier 3 services in order to continue to have access to dietetic, clinical behavioural and, psychological advice and support to help them modify their lifestyle to maintain weight loss/reduction and to prevent or minimise complications<sup>6</sup>.

Access to the Level 4 bariatric service has been limited for Cwm Taf Morgannwg patients, as they are required to have engaged in a Level 3 service for two years prior to referral to Level 4. The Welsh Institute of Metabolic and Obesity Surgery provides this service in Swansea. The following data table shows the number of patients from Cwm Taf who have been referred to, and either accepted or declined bariatric surgery since 2011. The health board currently contributes to the Welsh Health Specialised Services Committee towards the provision of this all Wales service.

Latest data available:

| <b>All Bariatric Referrals to ABMU/Swansea Bay</b>         |                     |           |           |           |           |           |           |           |          |
|--|---------------------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|----------|
| As at 26/05/2021   |                     |           |           |           |           |           |           |           |          |
| Area   | 2014/15             | 2015/16   | 2016/17   | 2017/18   | 2018/19   | 2019/20   | 2020/21   | 2021/22   |          |
| Bridgend   | 10                  | 6         | 9         | 15        | 12        | 26        | 18        | 2         |          |
| Cwm Taf  | 9                   | 8         | 14        | 18        | 39        | 51        | 19        | 4         |          |
| <b>Total</b>   | <b>19</b>           | <b>14</b> | <b>23</b> | <b>33</b> | <b>51</b> | <b>77</b> | <b>37</b> | <b>6</b>  |          |
| <b>Bridgend residents referred to Bariatrics</b>           |                     |           |           |           |           |           |           |           |          |
| Subspec  | Clinical Condition  | 2014/15   | 2015/16   | 2016/17   | 2017/18   | 2018/19   | 2019/20   | 2020/21   | 2021/22  |
| Bariatric Surgery  |                     |           |           |           |           | 1         | 3         |           |          |
|  | BARIATRICS(RTT EXC) |           |           | 1         | 11        | 10        | 22        | 17        | 2        |
| General Surgery  | BARIATRICS(RTT EXC) | 1         | 1         | 4         | 4         | 1         | 1         | 1         |          |
| General Surgery RTT exclusion                              | BARIATRICS(RTT EXC) | 9         | 5         | 3         |           |           |           |           |          |
| GS Endoscopy Direct Access                                 | BARIATRICS(RTT EXC) |           |           | 1         |           |           |           |           |          |
| <b>Total</b>   |                     | <b>10</b> | <b>6</b>  | <b>9</b>  | <b>15</b> | <b>12</b> | <b>26</b> | <b>18</b> | <b>2</b> |
| <b>Bridgend and Cwm Taf Residents: Outcome of Referral</b> |                     |           |           |           |           |           |           |           |          |
| Outcome  | 2014/15             | 2015/16   | 2016/17   | 2017/18   | 2018/19   | 2019/20   | 2020/21   | 2021/22   |          |
| Become outpatient  | 18                  | 13        | 23        | 29        | 45        | 33        | 9         | 2         |          |
| Outpatient list  |                     |           |           |           | 4         | 12        | 6         | 2         |          |
| Died   | 1                   |           |           |           |           |           |           |           |          |
| Hospital Fault   |                     |           |           | 1         | 2         | 1         |           |           |          |
| Inappropriate Referral                                     |                     |           |           | 1         |           | 31        | 22        | 2         |          |
| Treatment no longer required                               |                     | 1         |           | 2         |           |           |           |           |          |
| <b>Total</b>   | <b>19</b>           | <b>14</b> | <b>23</b> | <b>33</b> | <b>51</b> | <b>77</b> | <b>37</b> | <b>6</b>  |          |

Source: Information department, Swansea Bay UHB

## **Governance of the integrated service**

It is proposed that the Level 3 service will be located in a health care setting, and the Level 2 service in community venues and primary care settings.

The service will be housed in the Primary Care directorate. Reporting and governance would be through the Primary and Community Care Committee.

The service will adhere and report to the minimum data set as set out in the All Wales Pathway. Routine service monitoring, data and service user feedback will be used to improve service uptake, retention, delivery and improvement.

## **RESEARCH AND DEVELOPMENT**

Cwm Taf Morgannwg University Health Board Research & Development (R&D) department has agreed to support the design and delivery of a research study to evaluate the new Level 3 obesity pathway. Working alongside Public Health Wales (PHW), as well as relevant stakeholders across primary and secondary care, R&D can specifically help to design a study to determine whether or not the new pathway is fit-for-purpose in the views of the service users themselves. By obtaining permission to 'follow' service users throughout their Level 3 journey, quantitative data (e.g. weight reduction) as well as complementary qualitative data (e.g. direct feedback on the pathway using surveys and/or semi-structured interviews) can be collected and analysed. Results can be fed back into the design of the pathway to ultimately improve service delivery going forward. The R&D department can support the development of study-specific documentation (e.g. Protocol, Participant information sheet, Consent Form, data capture forms, surveys, questionnaires) as well as the acquisition of the regulatory approvals needed to start data collection too.

Recognising the need for a Level 3 obesity pathway, CTM UHB R&D department has already provided monies to a primary care site to design and deliver a research study to address this. The site has a track record in successfully delivering research studies and is willing to align its work and use the funds it has already received to complement the work now being led by PHW.

## **INTEGRATED L2/3 ADULT WEIGHT MANAGEMENT SERVICE CAPACITY, COSTS AND ROLES**

In order to maximise inter-professional efficiencies around shared skill sets, the workforce in this service needs to be flexible. The staff commissioned externally or employed by the health board in Level 2 will link closely with the programme manager and the MDT of the Level 3 service. This would ensure continuity of staffing in the service and provide interest and variety in staff roles.

### Initial Service Capacity:

|                             |            |
|-----------------------------|------------|
| <b>Level 2 JCP +</b>        | <b>500</b> |
| <b>Level 2 Dietetic Led</b> | <b>875</b> |
| <b>Level 3</b>              | <b>100</b> |

*NOTE: Patients can receive treatment in L3 for up to 24 months, so this number would increase in the second and subsequent years. In addition, patients referred back from Level 4 will need to be seen in the Level 3 service and assessed for long-term support.*

The integrated Level 2/3 weight management service will support the prescribing of obesity medication and assess the outcomes in prescribing via Primary Care and the Live Well service.

### Costs

| <b>Post</b>  | <b>Band</b> | <b>WTE</b> | <b>Cost £</b>    |
|--|-------------|------------|------------------|
| <b>Service management</b>  |             |            |                  |
| <b>Pay</b>   |             |            |                  |
| <b>Co-ordinator/Manager (dietitian, physio, senior nurse - wide job spec to fit best person to the role)</b> | <b>8a</b>   | <b>0.8</b> | <b>52,012</b>    |
| <b>Triage and assessment dietitian/psychologist</b>  | <b>7</b>    | <b>1.0</b> | <b>55,831</b>    |
|  |             |            |                  |
| <b>Administration for AWMS</b>   | <b>4</b>    | <b>0.8</b> | <b>23,801</b>    |
|  | <b>2</b>    | <b>1.0</b> | <b>23,573</b>    |
| <b>Total pay</b>   |             | <b>3.6</b> | <b>155,217</b>   |
|  |             |            |                  |
| <b>Non-pay</b>   |             |            |                  |
| IT equipment – non-recurrent   |             |            | 7,500            |
| Running costs – stationary, telephone, postage   |             |            | 1,866            |
| Total non-pay  |             |            | 9,366            |
|  |             |            |                  |
| <b>Sub total</b>   |             |            | <b>£ 166,583</b> |

|                             |  |  |  |
|-----------------------------|--|--|--|
| <b>Level 2 Option A</b>     |  |  |  |
| <b>JCP + (500 patients)</b> |  |  |  |
| <b>Pay</b>                  |  |  |  |

|  |                          |             |                 |
|--|--------------------------|-------------|-----------------|
| <b>Exercise Referral Specialist</b>  | <b>Local Authority 6</b> | <b>0.85</b> | <b>25,054</b>   |
| <b>Dietetic Advanced Practitioner</b>                                      | <b>Band 4</b>            | <b>2.5</b>  | <b>74,379</b>   |
| <b>Dietitian</b>   | <b>Band 6</b>            | <b>1.40</b> | <b>66,297</b>   |
|  |                          |             |                 |
| <b>Total Pay</b>   |                          |             | <b>£165,730</b> |
|  |                          |             |                 |
| <b>Non-pay</b>   |                          |             |                 |
| Travel   |                          |             | 3,600           |
| Running costs – stationary, telephone, postage                             |                          |             | 501             |
| Venue costs – not included, but some partners request these as part of SLA |                          |             | TBC             |
| Training   |                          |             | 700             |
|  |                          |             |                 |
| Total non-pay  |                          |             | 4,801           |
|  |                          |             |                 |
| <b>Sub-total</b>   |                          |             | <b>£170,531</b> |

|  |          |            |                 |
|--|----------|------------|-----------------|
| <b>Level 2 Option B</b>                        |          |            |                 |
| <b>Dietetic led model 875 patients)</b>        |          |            |                 |
| <b>Pay</b>                                     |          |            |                 |
| <b>Physiotherapist</b>                         | <b>6</b> | <b>1.0</b> | <b>47,355</b>   |
| <b>Physiotherapy Technician</b>                | <b>4</b> | <b>1.0</b> | <b>29,752</b>   |
| <b>Dietitian</b>                               | <b>6</b> | <b>3.6</b> | <b>170,477</b>  |
|  |          |            |                 |
| <b>Total Pay</b>                               |          |            | <b>£247,584</b> |
|  |          |            |                 |
| <b>Non-pay</b>                                 |          |            |                 |
| IT equipment, non-recurrent                    |          |            | 9,000           |
| Travel   |          |            | 10,800          |
| Running costs – stationary, telephone, postage |          |            | 2,449           |
| Equipment - scales                             |          |            | 2,500           |
| Training                                       |          |            | 2,100           |
| <b>Total non-pay</b>                           |          |            | <b>£26,849</b>  |
|  |          |            |                 |
| <b>Sub-total C</b>                             |          |            | <b>£274,433</b> |

|                    |  |  |  |
|--------------------|--|--|--|
| <b>Level 3 MDT</b> |  |  |  |
| <b>Pay</b>         |  |  |  |

|   |           |             |                 |
|---|-----------|-------------|-----------------|
| <b>Consultant Physician</b>   |           | <b>0.15</b> | <b>19,777</b>   |
| <b>Nurse</b>  | <b>5</b>  | <b>0.15</b> | <b>5,704</b>    |
| <b>Dietitian</b>  | <b>7</b>  | <b>1.35</b> | <b>75,372</b>   |
|   |           |             |                 |
| <b>Principal Clinical Psychologist</b>  | <b>8b</b> | <b>1.0</b>  | <b>78,260</b>   |
| <b>Physiotherapist</b>  | <b>6</b>  | <b>0.5</b>  | <b>23,677</b>   |
| <b>Generic Therapy Tech</b>   | <b>4</b>  | <b>1.0</b>  | <b>29,752</b>   |
|   |           |             |                 |
|   |           |             |                 |
| <b>Total pay</b>  |           |             | <b>232,542</b>  |
|   |           |             |                 |
| <b>Non-pay</b>  |           |             |                 |
| Equipment x 1 pilot site (e.g. Dewi Sant)   |           |             |                 |
| Scales, including wheelchair scales   |           |             | 4,000           |
| Other equipment e.g. Theraband, BP cuffs etc.   |           |             | 1,000           |
| ADL equipment   |           |             | 1,000           |
| IT equipment, non-recurrent   |           |             | 13,500          |
|   |           |             |                 |
| Running costs – stationary, telephone, postage etc.   |           |             | 4,711           |
| Training  |           |             | 3,150           |
| Pharmaceutical costs  |           |             | TBC             |
| Diagnostic tests?<br>• HbA1c and<br>• lipid profile<br>• thyroid function<br>• hormone profile test |           |             | 8,000           |
|   |           |             |                 |
| <b>Total non-pay</b>  |           |             | <b>7,432</b>    |
|   |           |             |                 |
|   |           |             |                 |
| <b>Total: Level 3</b>   |           |             | <b>£239,974</b> |

|  |                 |
|--|-----------------|
| Total cost for Level 3, Management and Option A        | <b>£577,061</b> |
| Total cost for Level 3, Management and Options A and B | <b>£851,494</b> |

**We anticipate that £371,000 will be available from Welsh Government/ Healthy Weight Healthy Wales settlement each year to support the development of these proposals.**

*Note: Total settlement from HWHW is £439,000. The Joint Care Programme has been expanded to be delivered across the whole of CTM (to include Bridgend). This expansion will take £55,000 from the existing budget per year. An additional £13,000 has been identified for administration/coordination costs.*

## **Additional service developments**

- Website development is necessary for both service users and for clinical professionals to provide information about the pathway and referral mechanisms.
- Information resources (both tradition and digital media) to promote the service.
- Step down opportunities such as leisure services, community groups, third sector and low cost or free signposting for service users should be mapped and cascaded to relevant partners (Primary Care, PSB partners etcetera).

## **IMPLEMENTING THE SERVICE**

Implementing an integrated Level 2/3 adult weight management service from scratch will be a significant undertaking for the health board. As there has not been a service to date, it is problematic to predict with certainty what the demand and uptake will be.

Gradual implementation of a service will ensure that service user feedback is taken in to account offering an active voice to our population.

- Implement the Level 3 service initially from one location with good transport links - use a central setting such as the upgraded and refurbished Dewi Sant facility in Pontypridd. Engagement is needed with service users on the acceptability of a single site option in terms of access, uptake and retention.
- Prioritise target groups in to Level 3 initially:
  - Type 2 diabetes referrals from the proposed diabetes health park
  - High need/high complexity patients identified via gastroenterology/local liver plan
  - Referral of Health Check patients into Level 2 services
  - Referral of obese patients who are identified by the pre-diabetes pilot

## **Impact of weight management services**

Small degrees of weight loss can produce health benefits, but significant improvements are seen after a loss of 5 - 10% total body weight<sup>7</sup>. As little as 10kg of weight loss can produce the following benefits<sup>8</sup>:

| <b>Clinical aspect</b>                          | <b>Benefit</b>  |
|---|---|
| Mortality                                       | <ul style="list-style-type: none"> <li>• 20-25% reduction in total mortality</li> <li>• 30-40% reduction in deaths related to diabetes</li> <li>• 40-40% reduction in obesity-related cancer deaths</li> </ul>  |
| Blood pressure - in people who are hypertensive | <ul style="list-style-type: none"> <li>• 10mmHg reduction in both systolic and diastolic values</li> </ul>  |
| Diabetes – in people newly diagnosed            | <ul style="list-style-type: none"> <li>• 30-50% reduction in fasting glucose</li> <li>• 15% reduction in HbA1c</li> </ul>   |
| Lipids  | <ul style="list-style-type: none"> <li>• 10% reduction in total cholesterol</li> <li>• 15% reduction in low density lipoprotein cholesterol (LDL-C)</li> <li>• 30% reduction in triglycerides</li> <li>• 8% increase in high density lipoprotein cholesterol (HDL-C)</li> </ul> |
| Other benefits                                  | <ul style="list-style-type: none"> <li>• Improved lung function, insulin sensitivity and ovarian function</li> <li>• Reduced back pain, joint pain, breathlessness and sleep apnoea</li> </ul>  |

Changes in diet, physical activity and behaviour are needed to achieve sustained long term weight loss.

## **COORDINATING PROGRAMMES OF WORK ACROSS CTMUHB RELATED TO WEIGHT MANAGEMENT**

There are two specific projects currently being developed that will dove-tail alongside the weight management service proposals.

One programme under consideration is a dietetic-led weight management and physiotherapy pain release programme targeted at patients on the orthopaedic, gynaecology, pain, diabetes and liver disease waiting lists. This programme will support patients via 1 to 1 and groups with intensive nutrition and behavioural support intervention alongside an exercise component. This programme would delivered an advanced level 2 weight management service mode of delivery for a cohort of approximately 400 patients. This is a fixed-term and will target patients at BMI 30-40 with co-morbidities to reduce the weight of those on the secondary waiting lists. The outcomes during and post-surgery and/or treatment are significant and well documented (cite).

Primary Care Wellness Hubs is the second project that will deliver healthy lifestyle behaviour support to patients on secondary waiting lists predominantly targeted at cardiovascular disease. Referral criteria is still being defined but it is expected that

the Wellness Hub work will target patients at level 1 of the weight management pathway ensuring that this work complements and underpins the pathway proposals and does not duplicate.

## **COST AVOIDANCE**

The costs to the NHS and society from overweight and obesity are well documented. Obesity alone will cost NHS Wales around £500 million per year by 2050 with a wider cost to the nation of £2.4 billion per year<sup>9</sup>.

Modelling by Public Health England, using a weight management assessment tool, has shown that for every £1 spent on weight management intervention projects, with an average uptake of 30% and did not complete at 30%, the project will save £1.27 in healthcare and social care costs at the end of year four<sup>10</sup>.

## **CONCLUSIONS**

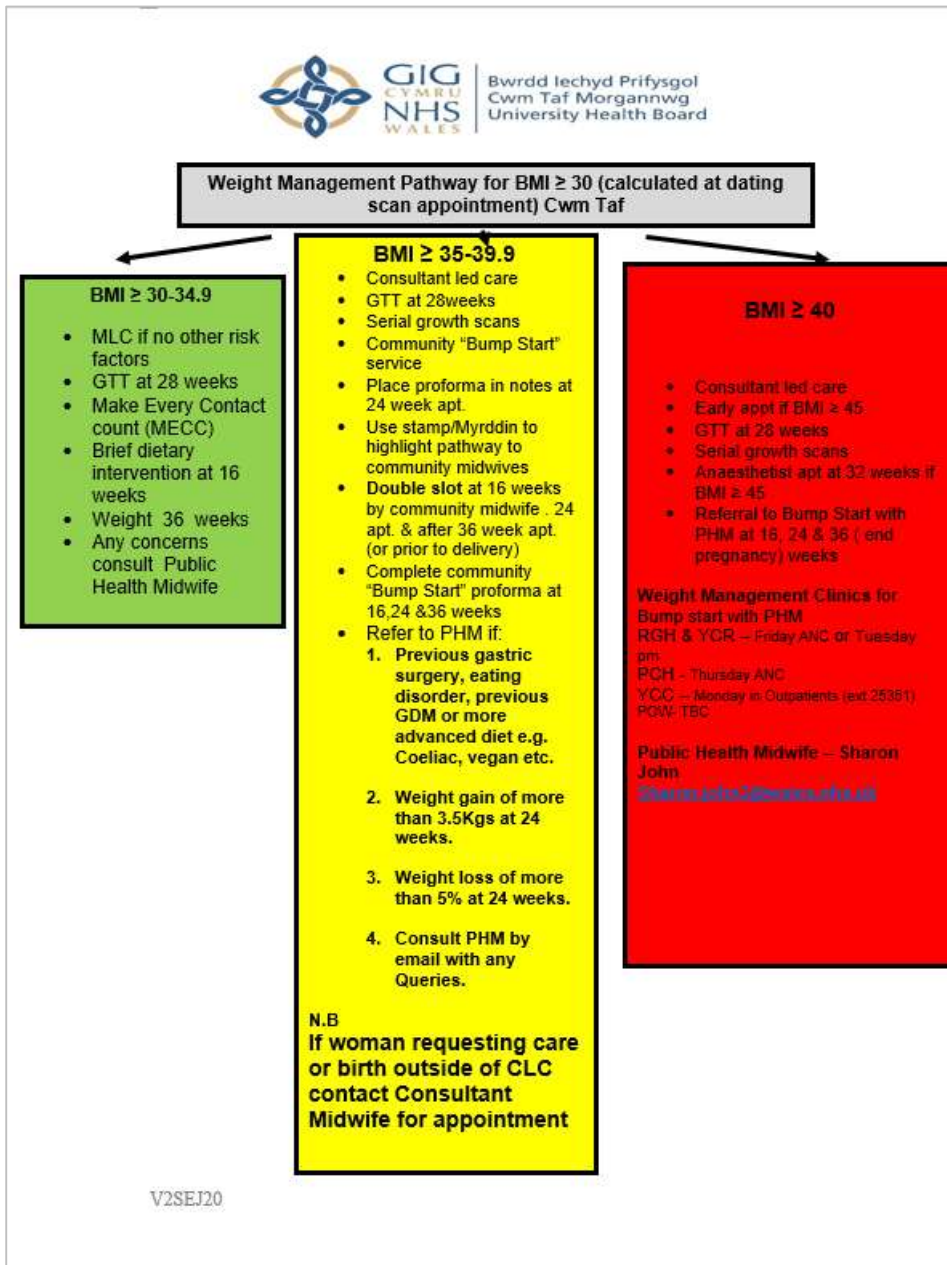
- Obesity is a preventable and treatable cause of ill health and premature death<sup>11</sup>
- There are insufficient adult Level 2 weight management services, no Level 3 service and very limited access to the Level 4 service for our patients
- A 'do nothing option' is not viable as the impact of obesity related conditions threatens the sustainability of NHS services in Cwm Taf Morgannwg
- The health board has a duty to improve health, address health inequalities, comply with the sustainable development principle and is encouraged to use the principles of Prudent Healthcare.

## **RECOMMENDATIONS**

Members of the University Health Board are asked to:

- Note and discuss the service proposals
- Agree the implementation of an integrated Level 2/3 adult weight management service in 2020/21
- Commit to supporting a wider Level 2/3 plan as outlined in pages 16-18.
- Establish a service implementation group as soon as possible to recruit staff and develop the policies, procedures and infrastructure needed to instigate the service from Q3 2021
- Commit to addressing obesity as a complex issue requiring preventative action across the system.

## Appendix 1: Weight Management Pathway for Pregnant Women BMI > 30



## APPENDIX 2: LEVEL 3 MDT ROLES

### Clinical lead Consultant/GPwSI

The patient would require full medical assessment and support with pharmacological aspects of obesity. This could be reviewing existing medication and poly-pharmacy and its effect on appetite and weight, or the assessment for suitability of prescribing one of the wide-ranging drug choices to support the management of obesity via appetite suppression, nutrient absorption or other factors. The medical team member would also be responsible for assessment of suitability and onward referral to Level 4 obesity services including bariatric surgery, and the transition of patients from tertiary Level 4 service back to the health board for ongoing care. Patients accessing Level 3 obesity services often have co-morbidities and the medical team member would link and signpost to other specialties for existing or emerging co-morbidities.

### **Nurse**

This will be a sessional requirement to support the Level 3 clinic.

### **Dietitian**

The dietitian would be core to the Level 3 service delivering specialist new patient one to one clinics as well as individual follow up sessions, both individually and in conjunction with psychologist or other members of the MDT. They would be assessing and implementing complex treatment plans that incorporates nutrition, behaviour and any psychosocial aspects of ability to follow intervention. There would be multi-disciplinary clinic and triage that would include the dietitian as well as the supervision and support of dietitians (both within Level 2 service and core), dietetic support workers and NERS staff in ensuring competency and skills in community Level 2 services. The highly specialist weight management dietitian could support the dietetic treatment of patients if admitted to hospital. The dietitian would allow step up intensive specialist advice for those entering the service but would also have input to those patients returning from Level 4 tertiary services, often with complex needs. They would also address the patients who choose to access bariatric surgery services privately and are then referred locally into secondary care services with associated nutritional problems and deficits.

### **Psychologist**

The psychologist needs to be at least a Band 8a post, given the complexity of psychological and mental health problems encountered in the services, often related to difficulties starting in childhood and continuing through adulthood. Psychologists are an essential staff needed for weight management programmes, as so many people are at the stage of being at risk of life-threatening problems and require specialist psychological intervention to make meaningful behaviour changes.

### **Physiotherapist**

Physiotherapists have a role to play in the prevention and management of obesity. Obesity leads to restrictions in movement, affecting engagement in physical activity. In particular, physiotherapists can support people overcome barriers to engaging with activity in relation to body image and associated comorbidities such as arthritis, back pain, and other musculoskeletal and chronic conditions, such as heart disease.

Physiotherapists are therefore ideally suited to address the physical and psychological complexities of obesity. Physiotherapists provide valuable input and expertise in the multi-disciplinary management of obesity, helping to optimise clinical outcomes and patient experience.

While the importance of being physically active is well recognised, in reality patients often experience difficulties in doing so. It is important to facilitate patients to increase physical activity at the right Level, which can be achieved by a physiotherapist. An assessment and treatment plan from a physiotherapist will help overcome the barriers to exercise

## REFERENCES:

- 
- <sup>1</sup> <https://www.nhs.uk/news/2007/Pages/Obesityinchildren.aspx>
- <sup>2</sup> NICE (2014) PH53: Managing overweight and obesity in adults – lifestyle weight management services
- <sup>3</sup> Katy Sutcliffe, Michelle Richardson, GJ Melendez-Torres, Claire Stansfield. James Thomas (2016) A systematic review to identify the programme characteristics, and combinations of characteristics, that are associated with successful weight loss, London: Department of Health
- <sup>4</sup> Institute of Employment studies (2019) Obesity and Work: Challenging stigma and discrimination, Brighton; IES
- <sup>5</sup> Bariatric surgery for obesity and metabolic conditions in adults, David E Arterburn & Anita P Courcoulas et al, British Medical Journal, 2014: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4707708/>
- <sup>6</sup> WHSSC (2018) Specialised services service specification CP29b: Bariatric Surgery
- <sup>7</sup> Care pathway for the management of overweight and obesity, Department of Health Best Practice Guidance (May 2006)  
[http://www.htmc.co.uk/resource/data/htmc1/docs/Care%20pathway%20for%20the%20management%20of%20overweig ht%20and%20obesity.pdf](http://www.htmc.co.uk/resource/data/htmc1/docs/Care%20pathway%20for%20the%20management%20of%20overweig%20ht%20and%20obesity.pdf)
- <sup>8</sup> Zakeri, R and Batterham R (2017) Improving Health Through The Provision of Weight Management Services, London: Centre for Obesity Research
- <sup>9</sup> <https://www.rcplondon.ac.uk/news/we-cannot-underestimate-scale-challenge-tackling-welsh-governments-obesity-strategy>
- <sup>10</sup> <https://khub.net/documents/31798783/32394974/Weight+management+economic+assessment+tool+-+version+2+-+User+guide.pdf/ec1167d2-2aa8-4c23-bd9e-d2eaab209b8e>
- <sup>11</sup> Welsh Government (2019) Healthy Weight: Healthy Wales strategy consultation document